SMRH Service Request Form

Consumer Information	
Consumer Name:	Birth Date:
Street Address:	City:
County:	Zip Code:
Medicaid Number:	SSN:
Phone Number:	
Developmental Disability Diagnosis:	
Level of Intellectual Disability: ☐ Severe ☐ Profound ☐ Moderate ☐ Mild ☐ Borderline ☐ N/A	
Does the person have a current mental health diagnosis? ☐ Yes ☐ No	
Mental Health Diagnosis:	
Does the person have a current Person Centered Plan (PCP)? ☐ Yes ☐ No PCP Date:	
Does the person have an HCBS Plan of Care? ☐ Yes ☐ No	
Current Medications, Dosage/Frequency and Purpose:	
Medical Issues:	
Current placement and history of previous placements:	
Has he/she hurt someone? ☐ Yes ☐ No Has he/she hurt self? ☐ Yes ☐ No	

Parent/Guardian Information	
Parent/Guardian Name:	
Street Address:	City:
County:	Zip Code:
Phone Number:	Mobile Number:
E-Mail:	

Agency Information

Is a Community Developmental Disabilities Organization (CDDO) involved? ☐ Yes ☐ No If yes, has the CDDO been notified of referral? ☐ Yes ☐ No		
CDDO:		
Is there a current Developmental Disability Profile (DDP) or BASIS? ☐ Yes ☐ No		
Community Service Provider:		
Case Manager's Name:		
Street Address:	City:	Zip Code:
1st Phone Number:	2nd Phone Number:	
Fax Number:	E-Mail:	
Date QEC was contacted by CDDO:		
QEC Name:	E-Mail:	
Phone Number:	Fax Number:	
Is the individual currently receiving mental health services? ☐ Yes ☐ No		
Other mental health services:		
CMHC:		
CMHC Case Manager:		

Person Making Contact

Contact Name:	Phone Number:
Affiliation:	
Agency requested: ☐ KNI ☐ PSH&TC	

Requested service(s) (one or more):

☐ Admission ☐ Behavioral/Psychiatric Consultation ☐ Dental

☐ Medical Consultation ☐ Outpatient Sex Offender Treatment Consultation (PSH&TC)

DDT&TS/Outreach services: ☐ Behavior Consultation ☐ Staff Training Services

Evaluation/Assessment:

☐ OT/PT/Adaptive Equipment ☐ Speech/Hearing

☐ Psychological

☐ Other service(s) requested:

Notes on service(s) requested:

Date of Request:

DUAL DIAGNOSIS TREATMENT & TRAINING SERVICES
PARSONS STATE HOSPITAL & TRAINING CENTER

Person being served:

Name: _____ Birth Date: _____

Where does the person live? Please check one of the following:

- ☐ At home with immediate family
- ☐ At home with a foster family
- ☐ At home with a relative
- ☐ By him/herself
- ☐ In a home with 8 or fewer residents
- ☐ In a facility with more than 8 residents

Other: _____

DEVELOPMENTAL DISABILITIES AGENCY INFORMATION

Developmental Disability: _____

Tier Level: ____

Community Developmental Disabilities Organization (CDDO):

_____

Community Support Provider (CSP) Information:

Agency(ies)_____

Day Services:_____

Residential Services: _____

Developmental Disabilities Case manager: _____

Case manager's office address: _____

_____ _____
City Zip

Case manager's phone number: _____

Case manager's mobile phone number: _____

Case manager's email address: _____

MENTAL HEALTH AGENCY INFORMATION

Is the individual currently receiving mental health services? ☐ Yes ☐ No

Psychiatrist: _____

Community Mental Health Center (CMHC) information, if utilized:

CMHC _____

_____ _____ _____
Street Address City Zip

CMHC phone number_____

CMHC mobile phone number:_____

Mental Health (MH) Therapist: _____

MH Case manager: _____

Mental Health Diagnoses

Please list only the current mental health diagnosis

Diagnosis *Age of Onset if known*

_____

_____

_____

_____

Hospitalizations

Has the person ever been hospitalized *for behavioral or emotional problems*?

☐ No

☐ Yes If yes, please provide the hospital name and the admission and discharge dates for each.

Hospital	Admission Date	Discharge Date

SCHOOL INFORMATION

Is the person CURRENTLY in school? ☐ Yes ☐ No Highest grade this person has completed:_____

Does this person currently have behavioral problems at school? ☐ Yes ☐ No

Would you like an outreach consultant to work with your child's school? ☐ Yes ☐ No

Name of Teacher _____

Name of School _____

School Address _____

School Phone _____

BEHAVIORAL INFORMATION

Has a behavioral specialist been consulted prior to today? ☐ Yes ☐ No

If yes, please indicate the type of practitioner providing behavioral consultation.

☐ Psychologist ☐ Autism Specialist ☐ School Behavioral Consultant

☐ Behavioral Analyst ☐ Positive Behavior Supports Specialist ☐ Other

Please indicate whether this individual has been involved with any of the following in the **past 3 months**

☐ Yes ☐ No

1. The Judicial system
2. Social Services
3. Inpatient Mental Health Treatment

Has this person previously received services from DDT&TS Click to select

If yes, please provide the date(s) for previous consultations

_____

In the Past THREE Months (ONLY):

1. Did the person injure him/herself? For example, did the person bite him/herself, insert items into body cavities or into the skin, bang his/her head on the wall or floor, etc.? ☐ Yes ☐ No
2. Did the person hit, scratch, kick, bite, or otherwise physically attack others? ☐ Yes ☐ No
3. Did the person display behaviors such as screaming, crying, tipping over furniture, knocking materials to the floor, etc.? ☐ Yes ☐ No
4. Did the person destroy or damage property (i.e., breaking windows, throwing furniture, tearing up clothing, etc.)? ☐ Yes ☐ No
5. Did the person demonstrate noncompliance? ☐ Yes ☐ No
6. Was the person verbally aggressive against others? ☐ Yes ☐ No

How often do these behaviors currently occur? ☐ Hourly ☐ Daily ☐ Weekly ☐ Monthly or less often

How severe are the behaviors? ☐ Mild: disruptive with little risk to property or health
☐ Moderate: property damage or minor injury
☐ Severe: significant threat to health or safety

Situations in which behavior is most likely to occur:
Days/Times _____
Settings/Activities _____
Persons Present _____

What usually happens right *Before* the behavior?

_____

_____

_____

What usually happens right *After* the behavior?

_____

_____

_____

Please return all documents to the Admissions Coordinator, Karen VanLeeuwen at fax number: 620.423.0419

or

Director of Dual Diagnosis Treatment and Training Services, Dr. Renee' Patrick at fax number: 620.421.1499

Parsons State Hospital & Training Center
Dual Diagnosis Treatment & Training Services
2601 Gabriel Avenue, PO Box 738
Parsons, KS 67357-0738
Ph: (620) 421-6550 x1695 Main Fax: (620) 421-3623 DDT&TS Fax: (620) 421-1499

I authorize the release of information for/to Parsons State Hospital & Training Center/Dual Diagnosis Treatment & Training Services:

NAME _____ BIRTH DATE _____

ADDRESS _____ SSN_____

↑ TO ↑ FROM The following Agency/Individual:

_____
Name Position/Relationship Phone

_____
Agency Street Address

_____
City State Zip Fax

Information is to include: All medical, social, psychological, behavioral, educational, psychiatric and other pertinent information **OR**	Information is to be used for:
☐ Medical ☐ School ☐ Social ☐ Behavioral ☐ Special Education ☐ Psychiatric ☐ Psychological Other _____	☐ Placement purposes ☐ Treatment planning ☐ Consultation and recommendations ☐ To assist with legal proceedings ☐ To assist others in planning/providing services ☐ Educational planning/placement Other _____

This Authorization expires on _____.
If left blank authorization will expire 30 days after the case is closed.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian (relationship) Date

_____ _____
Signature of Witness Date

Consent will not be considered valid without a witness' signature and a client or parent/guardian signature. A public notary is not necessary. I understand that I am not required to sign this release, and if signed, I may revoke it at any time, except to the extent that is required by law. To revoke this authorization, I may contact PSH&TC in writing. I understand that PSH&TC cannot require a signed release as a condition of services unless permitted by law. I have the right to inspect or copy any consultation recommendations provided by PSH&TC. I understand that records obtained by PSH&TC may include HIV, psychiatric, alcohol, or drug abuse information. Information gathered by PSH&TC may include psychological and behavioral information. This information may be protected by State and Federal laws and regulations. I understand that if the information is collected by someone who is not a health care provider it may be re-disclosed and is no longer protected by privacy regulations. I hereby release and discharge PSH&TC/indicated Agency and the person or entity to or from which the above information is provided/received and their employees from any liability for the release of any information disclosed pursuant to this authorization.
Form updated: 12/29/11

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CONSENT FOR VIDEOTAPING

I/we authorize Parsons State Hospital/Dual Diagnosis Treatment & Training Services (DDT&TS) to videotape my son/daughter/ward/self _____ as deemed necessary to evaluate behavior(s). This tape will be used for evaluation and training (e.g., in-servicing staff, presentations, etc.) purposes only. I understand that I have the right to withdraw this consent at any time and that I have the right to view any videotape made of my son/daughter/ward. I understand that the videotapes may be kept for future reference by the DDT&TS team following the consultation, but will not be released to anyone without my express written consent to release any videotape(s).

This consent will expire on _____
If left blank, this consent will expire 30 days after the case is closed except as indicated above.

_____ _____
Client/Consumer Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.

Form updated: 12/29/11

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CONSENT FOR EVALUATION AND TREATMENT

I/we grant permission for Parsons State Hospital and Training Center / Dual Diagnosis Treatment & Training Services (DDT&TS) team to complete a full evaluation of my son/daughter/ward/self, _____, which may include any or all of the following: observe; share information; review records, make behavior support recommendations; and, if necessary, pilot various behavior support strategies.

I realize when behavior supports are initiated there is the possibility of a temporary (i.e., few days or weeks) of increased or worsening of behaviors for which my son/daughter/ward was referred. I understand that all of the information regarding the evaluation will remain confidential.

This consent will remain in effect until it is expressly revoked in writing or until one year from the date signed, whichever occurs first.

_____ _____

Client/Consumer Signature Date

_____ _____

Parent/Guardian Signature Date

_____ _____

Witness Signature Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.

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Informed Consent/Assent to Allow Environmental Manipulations Procedures by the DDT&TS Outreach Consultation Team

I/we grant permission for the Dual Diagnosis Treatment & Training Services (DDT&TS) team to conduct environmental manipulations of the behavioral antecedents and consequences (Functional Behavior Analysis) for behavior exhibited by my son/daughter/ward/self, _____.
I understand that I may revoke this consent at any time. The behavioral antecedents and consequences of my son/daughter/ward's behavior are being manipulated so that the DDT&TS Outreach personnel can better determine the causes of behavior resulting in a referral for services. An additional purpose for these procedures is to provide the community support team with recommendations for behavioral planning that will likely lead to increased successful community living. I understand that manipulations of the antecedents and consequences of aberrant behavior can result in a temporary increase in those behaviors. I understand that the DDT&TS Outreach personnel conducting these manipulations will provide agency staff with training so that staff can be involved in this process. I further understand that these manipulations will not take place without a detailed outline provided in writing to the requesting agency and the parent/guardian (if applicable). This consent will remain in effect until it is expressly revoked or until one year from the date signed, whichever occurs first.

_____ _____
Client/ Consumer Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Agency Personnel Position Date

_____ _____
Witness Signature Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.

Form updated 12/29/11

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CONSENT FOR Email

I/we authorize the Dual Diagnosis Treatment & Training Services (DDT&TS) to communicate with community support team members about my son/daughter/ward/self _____via electronic mail/communication service. I understand that this communication cannot be guaranteed to be secure.

RISKS ASSOCIATED WITH EMAIL

Some, but not all, of the risks with email are listed here:
- Email can be immediately broadcast worldwide and received by many intended and unintended recipients;
- Email senders can easily misaddress an email;
- Email is easier to falsify than handwritten or signed documents;
- Backup copies of email may exist even after the sender or recipient has deleted his or her copy;
- Employers and on-line services have a right to archive and inspect emails transmitted through their systems;
- Email can be intercepted, altered, forwarded, or used without authorization or detection;
- Email can be used to introduce system computer viruses; and
- Email can be used as evidence in court.

I understand these risks and agree to allow the use of email for communication purposes.
Should I change my email address, I will notify DDT&TS. Should I decide to revoke consent for email communication, I will send written revocation by postal mail.
This consent will expire on _____.
If left blank, this consent will expire 30 days after the case is closed.

_____ _____
Client/Consumer Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date

NOTE: Consent will not be considered valid without a witness' signature and a client or parent/guardian signature.

Form updated: 12/29/11